Why Every Woman Over 40 Isn't in a Breast Cancer Detection Program

To THE EDITOR: Why isn't every woman over 40 in a breast cancer detection program? It is interesting to read the conclusion of Dr Robertson that the reason is poor compliance by physicians with screening recommendations.[1] The recommendations of the American Cancer Society and the American College of Radiology have the prestige, but it takes more than that. There are no uniform standards of care, preventive or otherwise, established by organized medicine or the government. Certainly, there are no mandatory requirements—which might not be a bad idea. The medical background, experiences, and practices of a half million physicians are divergent.

The elderly, the poor, the uneducated, and ethnic minorities are segments of the population not well penetrated by our health crusades. These groups are reluctant to seek medical advice when asymptomatic and often even with symptoms.

The middle class is more responsive to health education. Even here, however, asymptomatic persons have limited time, interest, and resources allocated to health. They are under a constant bombardment by medicine, family, and friends regarding diet, calories, salt, fat, sugar, cholesterol, calcium, vitamins, blood tests, cardiograms, pap smears, exercise, stress management, and so forth. The middle class shows a certain exhaustion from an overdose of health information.

Personality is a major key. Some people love to be medically pampered. They love interviews, examinations, tests, operations, whatever is fashionable. Others are uninterested or fearful of discovering an illness. They deny symptoms and reject an aggressive medical approach. They seek out health practitioners who are less forceful and demanding.

We physicians are also under economic pressures. It is difficult to coax an asymptomatic patient to have routine physicals or preventive tests at a time when insurance companies will not cover them or they carry high deductibles. My perspective is one of the general physician-surgeon: a complex of social, psychological, and economic problems. Why isn't every woman over 40 in a breast cancer detection program? I think that all women are, to the extent reality permits. We cannot force a mammogram as we can force a vaccination for a child or a pap smear for a woman on birth control pills. In spite of these difficulties, the use of mammograms and discovery of early cancers are increasing but not faster than the sophistication and prosperity of the general population.

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REFERENCE

1. Robertson CL: Why isn't every woman over 40 in a breast cancer detection program? West J Med 1988; 149:111-112

Economies of Scale

To THE EDITOR: In your editorial, "On Specialized Centers for Patient Care" in the July 1988 issue,[1] you discussed the economies of scale thought to exist in specialized care centers, and you stated that economies of scale result in better quality of specialized care given at the specialized care center. Improved cost of such care, however, was not confirmed because supporting data were not available.

It seems sensible, a priori, that greater experience derived from providing frequent replication of highly complex care would produce a better technical quality in a shorter elapsed time. But lower costs for this care will not result so long as a piecework payment (fee for service) system exists. If cost economies of scale are to be realized, large-volume, complex technical care will have to be provided by salaried technicians, working at hourly payment rates, with incentives to increase productivity.

Because physician payment is not yet made at hourly rates, it appears ridiculous to expect economies of scale to apply to physician services.

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REFERENCE

1. Watts MSM: On specialized centers for patient care (Editorial). West J Med 1988; 149:80

Fluoride in Mineral Water

To THE EDITOR: Commenting on an article by Russell and colleagues in the November 1987 issue,[1] Dr Robert Isman, Chief, Office of Dental Health, Department of Health Services, State of California, stated that " 'Such heavy exposure is associated with a level of at least 10 ppm in the drinking water supply.' These fluoride levels do not exist in the US, and there have been no reported cases of crippling fluorosis in the United States."[2]

Dr Isman may be correct in asserting that there have been no reported cases of crippling fluorosis in the United States, but he is not correct in assuming that all drinking water supplies are under 10 ppm fluoride level.

In a lawsuit in San Francisco, Burton et al v Source Perrier et al (SF Superior Court Cir No. 810212), the Food and Drug Administration, in response to a Freedom of Information Act request about Calistoga bottled mineral water, provided numerous analyses of expensive bottled drinking water with fluoride levels in excess of 10 ppm. Calistoga Sparkling Mineral Water and Orange Flavored Mineral Water frequently exceeded the fluoride levels Dr Isman asserts do not exist in the US.

Further information may be obtained from Alioto & Alioto, 650 California Street, San Francisco, CA 94108.

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REFERENCES

1. Russell HH, Jackson RJ, Spath DP, et al: Chemical contamination of California drinking water. West J Med 1987; 147:615-622

2. Isman R: Fluoride contamination (Correspondence). West J Med 1988; 148:708-709

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Dr Isman Responds

To THE EDITOR: Dr LaDou is correct in his assertion that Calistoga bottled mineral water at one time contained fluoride levels in excess of 10 ppm. Since January 1, 1988, however, California law has required mineral water to be treated to reduce the concentration of any naturally occurring substance that exceeds the bottled water safety standards established by the Department of Health Services. For fluoride, these standards limit the concentration to between 1.4 and 2.4 ppm, depending on the annual average of maximum daily air temperatures. Mineral water producers who bottle